Office of Statewide Health Planning and Development
California Health Policy and Data Advisory Commission
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Proposed Minutes
Health Data and Public Information Committee
January 12, 2006

The meeting was called to order by Howard L. Harris, Chairperson, at 10:15 a.m. in Room 470 of the Bateson Building, 1600 Ninth Street, Sacramento, California.

Present:	Absent:
Howard L. Harris, Chair	Jay R. Benson
Vito Genna, CHPDAC Chair	Stephen Clark
Vickie Ellis	Jan Meisels Allen
Lark Galloway-Gilliam (via telephone)	Janice Ploeger Glaab
Dorel Harms	Santiago Muñoz
Denise Hunt	Hugo Morris
Debra Lowry	
Catherine Nichol	
Jacquelyn Paige	
Lisa Simonson Maiuro	
Terry Smith O'Rourke	
Darryl Nixon	

CHPDAC Staff: Kathleen Maestas, Acting Executive Director; Rebecca Markowich, Executive Assistant

OSHPD Staff: David M. Carlisle, M.D., Ph.D., Director; Teresa Smanio, Assistant Director, Legislation and Public Affairs; Michael Rodrian, Deputy Director, Healthcare Information Division; Joseph Parker, Ph.D., Health Quality and Analysis Division; Kendrick J. Kwong, Manager, Accounting and Reporting Systems; Jonathan Teague, Manager, Healthcare Information Resource Center; Candace Diamond, Manager, Patient Data Section; Scott Christman, GIS Coordinator; Ty Christensen, Accounting and Reporting Systems; and Rob Fox, Ginger Cox, Irene Ogbonna, and Starla Ledbetter, Patient Data Section

Introduction and Remarks: Committee Chair Howard Harris introduced Vito Genna, who was recently reappointed to the Commission and appointed Chair.

Mr. Genna commented that the Committee had not met for over one year. Dr. Harris has been a member of the Committee for several years and has agreed to Chair this very important committee.

The Governor's Office has been slow in making appointments/reappointments to the Commission. There are still several positions in which no appointments/reappointments have been made. The Commission has continued to hold meetings, but has not been scheduling committee meetings.

Mr. Genna announced that on January 3, 2006, he took a new position as Executive Director/CEO of Sierra View Homes in Reedley, California. The facility has three levels of care: the independent side, the assisted living, and the skilled side.

Approval of Minutes: The minutes of the May 21, 2004 meeting were approved.

OSHPD Director's Report: There have been some retirements within State Government. Succession planning is very much a central component of all State departments.

John Rosskopf, Chief Legal Council and Acting Chief Deputy Director has retired. He will be pursuing graduate studies. Beth Herse succeeded Mr. Rosskopf as Acting Chief Legal Counsel.

Mike Kassis, Deputy Director for the Healthcare Information Division, has retired from OSHPD. Michael Rodrian, formerly with the Department of Health Services in charge of the Vital Statistics Section, succeeded him.

Jacquelyn Paige retired as Executive Director of the Commission. Kathleen Maestas has been serving as the Acting Executive Director for CHPDAC, in addition to that of Administrator of the Rural Health Policy Council.

Teresa Smanio was appointed Assistant Director for Legislation and Public Affairs in mid-July.

Robert David was appointed Chief Deputy Director. Mr. David previously was with the Hospital Council of Northern California and also Assistant Secretary for the Health and Human Services Agency. Mr. David is well versed on health policy issues, with a special emphasis on hospital and delivery system issues.

Angela Smith Minnifield, formerly Executive Director of the Health Professions Education Foundation, has been named Deputy Director, Workforce and Community Development Division. After the retirement of Pablo Rosales, Candace Diamond temporarily acted as Acting Deputy Director of the Workforce Division until the position was filled.

Diane Pomoda has been named Acting Executive Director for the Health Professions Education Foundation. Dr. Gary Gitnick has been named Chair of Health Professions Education Foundation, formerly with the State of California Medical Board.

Julie Montoya, Executive Assistant in the Director's Office, has been promoted to a Staff Services Analyst position in the Workforce and Community Development Division. She

came to OSHPD from the Health and Human Services Agency about two and one half years ago.

The Governor gave his State of the State address recently. The deficit in the budget is shrinking and revenues have started to increase. He announced that he wants to focus on improving and repairing California's infrastructure.

Legislative Report: Teresa Smanio, Assistant Director, Legislation and Public Affairs

This is the second year of a two-year legislative cycle.

AB 1045 was signed by the Governor. This legislation requires that each hospital submit a listing of 25 commonly charged services and added the requirement that the hospitals submit 25 common outpatient services, effective January 1. There is a $100 penalty for non-submission. The purpose is to assist the public in being able to review different hospitals' charges for the purpose of shopping around for services. The hospitals have said this charge master was not developed for the public and the goal probably will not be met. Because of the manner in which the data are aggregated, it will be very difficult to make comparisons across hospitals for specific services because there is no standardization across hospitals or within hospital systems. The expected outpatient procedures are not defined. After OSHPD has collected this for a year or two, it can develop a uniform listing and require hospitals to submit those procedures.

There is some standardization on the inpatient side because the legislation requires OSHPD to create a list of the 25 most common inpatient DRGs and publish the charge for DRGs.

OSHPD has developed a pivot table, which is on the website that provides the top 25 DRGs for each hospital. These are being priced out according to the total charge information provided by the hospitals. A new pivot table will be available shortly and will show how each hospital stacks up on the statewide 25 list. Its utility to the consumer remains dubious because it is difficult to know how to price out a good medical service. The DRG is probably a better way to charge a service

Ms. Maiuro said that consumer awareness is further complicated by markups on those charge masters to various payers and whether that markup reflects greater profit, less efficiency by the hospitals, and how that differs across payers and the payer mix within the hospital.

Ms. Galloway-Gilliam said she would like to see a link to some of the quality performance information available, so that consumers are able to make that connection with ease. The outcome studies are not based on the DRG level. There are DRGs related to the CABG procedure but they are not defined based on DRGs, but on the ICD-9 codes and some exclusionary criteria. Administrative data are not used for CABGs. A separate clinical registry is used to collect clinical information from hospitals.

SB 162 (Ortiz) would establish the Department of Public Health. This would be a major undertaking and would require funding in the budget. The California Performance

Review was recommending reconstructing the public health areas and streamlining it by making major reforms. Reports have said this is the weakest part in State Government.

Update on Healthcare Information Division: Michael Rodrian, Deputy Director

Mr. Rodrian came from the Department of Health Services where he ran the Center for Health Statistics, the major component of which was birth and death information. It was also the steward for a great deal of OSHPD data and handled distribution inside of Health Services. Mr. Rodrian is very familiar with many of the staff at OSHPD.

Patient Data Section: Candace Diamond, Manager

MIRCal is the Medical Information Reporting for California System. OSHPD received test data for the fourth quarter of 2004 voluntarily from ambulatory surgery centers within hospitals and free-standing ambulatory surgery centers separately licensed in California. This voluntary period went well. At present, three quarters of live data from first, second and third quarters of 2005 have been received. Some data are now available for the public on the website.

This data collection was accomplished with the support and assistance of stakeholders. Seminars and teleconferences were held, bulletins were developed, staff attended conventions and conferences, and e-mails were sent to begin the reporting of data from these facilities. Staff also went on nine or ten site visits to ambulatory surgery clinics to learn everything they could about the clinics. The California Health Information Association (CHIA) is sponsoring seminars for a six-city tour in March, at which a staff member from the Information Resource Center will demonstrate some of the pivot tables.

Reporting for the last quarter of 2005 will begin in mid-February for outpatient data and the last months of inpatient data. There will be six report periods open at once. This is the single best improvement made to MIRCal, done at the request of the smaller ambulatory clinics. OSHPD formerly collected more than 3.9 million inpatient records annually, and now will be collecting approximately 15 million records with the addition of emergency room and ambulatory surgery centers.

About 470 hospitals report to OSHPD, with 338 having emergency departments. A total of 886 surgery centers report, about half free-standing and half in the hospitals. Compliance in reporting has been better than expected. Penalties began for the third quarter of 2005. There were eight penalties; three have been paid. For emergency departments, there was 100 percent compliance reporting for all quarters of 2005.

There is minimal editing for emergency and ambulatory surgery. Many problems are caught at the transmittal point, such as viruses or anything that does not meet the required format such as big gaps of missing data on each record or discrepancies in numbers. If the number of surgeries looks too low or too high, a report may be questioned. Basic edits include blanks and valid codes, correct payer information, etc. Some trend edits will be done, and staff is looking for duplicates.

In 2005, California Health Information Association presented the staff with a plaque for good customer service and protections for patient confidentiality. Staff also received an award from the National Association of Health Data Organizations, a national organization. The California Ambulatory Surgery Association wrote a glowing letter about staff.

There are still some software vendor problems. Vendors have not been as responsive as the surgical clinics would like them to be. Obtaining licensing information has been a problem. Often a clinic will just let the license lapse if it is going to close. There is a wide range of expertise of coders in the outpatient setting and with national standards. Many surgical clinics balk at giving Social Security numbers and race/ethnicity. OSHPD staff has done a lot of outreach explaining the benefits of giving the SS number to OSHPD. Many of the personnel in the clinics "wear several different hats" which makes it difficult to contact them.

Some small clinics submit data manually and will be able to submit data daily if they wish to do so. When the quarter is over, they formally submit the data to undergo the editing process. Extensions can now be requested online. Small clinics having no data to report can confirm this online. Some of the warning flags for 2006 data will again be turned on, some of which were in gray areas.

For emergency departments and ambulatory surgery, staff, the first trend edit will look at volume change. E-codes will be required for all diagnoses that appear to need an external cause of injury. Staff will look for duplicates.

In June and July, for the first time, invoices were sent out for the special fee assessment to free-standing ambulatory surgery clinics. Ms. Diamond asked for feedback on this process. She expects some negative feedback because the billings were based on an estimate. This fee was adjusted for the next cycle, based on actual 2005 data submitted.

The MIRCal system has a very extensive e-mail process of primary contact, secondary contact and sometimes a separate mailing to the administrator. Communication in this manner is available for a large percent of the facilities.

Regulations have not been completed to make the 50 cent assessment fee ongoing. Language was in the law only for the first couple of years. For the 430 facilities, the total amount is close to $500,000 in fees based on the estimates.

There is a two-page report profiling payer class, gender of the patient, manner of payment and some other demographics which is generated automatically, which is not based on the clinical data.

Recently Starla Ledbetter served as acting section chief for the Discharge Data Section while Ms. Diamond's acted in the capacity of Acting Deputy Director of the Workforce and Community Development Division.

Healthcare Resource Center: Jonathan Teague, Manager

OSHPD currently has 11 data bases. There is an annual financial and quarterly financial data report for hospitals. There is a similar set of reports for the long-term care facilities, both financial and utilization. There is utilization data for primary care clinics and specialty clinics. There is a utilization database for home health agencies and hospices. Patient level data are the primary research databases, and is known as inpatient databases. The two newest databases are the emergency department data and ambulatory surgery data.

The patient discharge data collects around 4 million records per year, including demographic data, age, race, ethnicity, gender, zip code, admission source, disposition, and payer source There is a wealth of clinical data in terms of diagnosis, procedures, E-codes, conditions present at admission and do-not resuscitate. With the addition of emergency department and ambulatory surgery data, OSHPD will be collecting about 15 million records a year. The content is very similar to the patient discharge data.

The data standards for emergency department and ambulatory surgery center conform to national standards used by other states and by the Federal Government. The data do not include economic information, such as charge information. The coding for sex, race, and disposition is different and some of the codes are alpha numeric. The codes in the discharge data are typically numeric in form.

Facility profile reports are automatically generated by MIRCal's system, and are available within 15 days of the close of the report period. There will be a public version of the patient data available on CD-ROM because of the size of the database. The data are de-identified to protect patient privacy. Facility profiles and patient origin, market share and casemix tables will be on Excel programs. There will be frequency tables using ICD-9 and E-code frequencies. The emergency department data will be linked to Vital Statistics death files; researchers and healthcare planners will have an interest in these linked data products.

There will also be an all-encounter emergency department file. With the patient discharge data, if one goes to the emergency room and leaves the same day without being admitted as an inpatient, this would be considered an encounter. If one is admitted to the hospital, even though entered through the emergency department, that will not show up in the emergency department record, but will show up as an inpatient record. To combine all of the encounters generated through the emergency department, whatever the outcome and disposition, will require a linkage to merge the inpatient data with the emergency department data. Some programming will need to be done. Staff would welcome suggestions as to the kinds of linked data products which OSHPD could provide, such as linkage between ambulatory surgery center data and the inpatient hospitalizations that may result
There are other data products available on the web. There's a wealth of information available from ALIRTS. California Perspectives in Healthcare is a report prepared every two years. The report on Racial and Ethnic Disparities has been requested nationally. OSHPD outcome studies, a glossary of healthcare terms. seismic safety standards law, and hospital building ratings are also available.

OSHPD has contracted with a researcher to produce the birth-linked cohort file, combining the vital statistics cohort file with patient discharge data. Typically, these are non-public files and are available through the confidential data request process. There is great demand for this data.

There is a patient discharge data file linked to Medi-Cal file. The Department of Health Services has custody of this information because of the Medi-Cal data.

Geographical Information System: Scott Christman, GIS Coordinator

In 1999, the Health and Human Services Agency commissioned a GIS study, looking at uses and opportunities for use by the entire Agency, which was delivered in 2000. By 2001, OSHPD was looking at implementing Geographic Information Systems in support of all its programs. An information technology initiative was developed in 2001 to look at the entire organization. A feasibility report was prepared, which was the formal process to develop an information technology project, which was approved by the control agencies, the Department of Finance and the Department of General Services. It was the first enterprise GIS project that was approved by the control agency. In 2002, before the actual formal project began, OSHPD did some internal pilot projects to demonstrate that this could be done and could apply the technology to some of the business areas in the organization.

In 2003, staff worked on the system's architecture planning, best practices of how to actually implement the infrastructure in terms of hardware, software, data, licensing, etc. IT staff also engaged in the medical service study area reconfiguration, partnering with the Healthcare Workforce and Community Development Division. This deals with the boundary lines and rational service areas that are the eligibility determinations for State and Federal healthcare funding opportunities of approximately $500 million. It was a great project to apply technology and freed up staff involved in the delivery systems to actually make decisions on how the boundaries were drawn.

In 2005, the focus was primarily on development of web application framework. Of greatest interest to the Committee, is the public internet application, a web-based application that uses GIS mapping for location of facilities and linking to a broader set of information, basically repackaging much of the information provided by OSHPD into one location.

Staff has been working on emergency operation center application for the Facilities Development Division for those that review and inspect hospitals and skilled nursing facilities after a seismic event. Geographical information will be combined with seismic information, hospital, SNF information, and construction information so that assessments can be made quickly after seismic events. There has also been some desktop work with GIS in modeling earthquake activity. Staff is looking at each hospital and the buildings on its campus, running it through a modeling application to determine how the buildings will perform structurally based on an earthquake.

The key focus in 2006 is to make the application available to the public. The patient origin and market share information is available on pivot tables on the website in a

tabular form, in an Excel spreadsheet. This can be made into a patient origin map to determine where a hospital's patients are coming from. In the market share, one can visualize by map where facilities are that are treating patients from a particular zip code or for a particular condition. Staff has been integrating the GIS interface with the data warehouse where multiple hospitals can be selected to look at more aggregate level conditions. Instead of looking at an individual DRG, multiple conditions could be looked at.

The focus groups showed much interest in information in a simple web application. The data will be user friendly, and still be able to give a wealth of information through one interface. The basic GIS information on licensed health facilities reporting to OSHPD will be available in a few weeks.

Jacquelyn Paige said that the Institute of Health and the National Library of Medicine will be ready by the end of March, through MedLine Plus, using OSHPD data to locate all the health facilities in local Los Angeles. This information is already available in five other cities, and this is the first time it is coming out west. By logging onto MedLine Plus, there is a resource base of over 170,000 health services available to those in the community. This will include all the hospitals, long-term facilities, clinics, pharmacies and physician offices.

OSHPD's approach to disseminating this kind of information is to use a packaging and publishing tool to combine information into a single location. OSHPD will package the mapping information, including healthcare facilities maps, data, actual point locations, and some of the data behind it, driven by the ALIRTS system, as well as the medical service study area maps and the health professional shortage areas. This information is available for download.

There is some fairly new technology, where a map layer of healthcare facilities can publish and another GIS application can be used. OSHPD is responsible for the information and does a good job of releasing and maintaining the data, and would prefer that data users obtain the information from OSHPD directly to better manage the use of the data.

There is a challenge in State Government to partner with other agencies such as the Department of Health Services' and Department of Public Health to provide a more comprehensive picture of healthcare services. County clinics are not licensed by DHS so OSHPD does not have this information.

There is a GIS Council, with no statutory authority, which has support for a geographic information office as a focal point for coordination among all State agencies. The Health and Human Services Agency has been voted as the Chair. Scott Christman and Mike Byrne act as a proxy for the Secretary to coordinate these issues. The greatest challenge is sharing resources. The budget contains a line item for GIS coordination, but no interagency agreements and moving of funds can be done.

Through a collaborative effort with the U. S. Department of Agriculture last year, the group was able to obtain aerial imagery of the entire state, where OSHPD can actually

look at the hospital campus structures and identify buildings that are either under construction or have been built. The product is worth about $5 million and the State paid about $300,000. It was a good partnership with the Federal Government.

OSHPD staff has been working closely with the Emergency Preparedness Office at DHS on how to get information quickly that is pertinent to a Katrina-like disaster, which would require a robust set of data and coordination across both agencies. OSHPD data is being recognized as being very valuable.

Revision of LTC Annual Disclosure Report for Implementation of AB 1629: Ty Christensen

The Long Term Annual Financial report is combined with the Medi-Cal Cost report, which OSHPD collects. DHS audits the data and uses the data to set rates. AB 1629 changes the way that free-standing SNFs are paid by Medi-Cal. In the past, they were paid a flat rate based on three geographic areas and based on whether the facilities had 59 beds or fewer beds, or 60 or more beds. Payment was also based on the median facility in the groupings and did not take into account the kind of care provided. AB 1629 sets up a facility-specific reimbursement rate specific to the facility, mostly driven by labor costs and capital improvement to encourage facilities to provide quality care. The legislation provided for a quality assurance fee paid by each facility, and matched by the Federal Government to fund the increased reimbursement. The overall legislation has a sunset date and can either be renewed or terminated.

The rates were to be effective August 1, 2005, based on 2003 data, which was the latest data at that time. DHS sent supplemental schedules to base the fee on until the information could be incorporated into the LTC financial reports. Proposed regulations to change the report need to be written and go through the approval process. OSHPD collects salaries, wages and benefits but does not collect labor that is contracted for. OSHPD reports currently are limited as to how much new data can be added, and the new data would not begin to be collected until after the sunset date. Facilities have increased their expenditures on staffing, etc. so the sunset date would most likely be extended. In signing the legislation, the Governor said he wanted to expand the quality measures, especially staffing.

The annual financial reports for long-term care and hospitals are currently on the mainframe computer. The programmers at OSHPD who supported these reports have retired, but have agreed to work as retired annuitants to do the required maintenance. When these reports migrate off the mainframe, extra data items could be added. Some of the items asked to be reported separately are agency costs and contracted costs, cost of liability insurance, caregiver training, license fees. DHS asks the facilities to report these separately on a supplemental report, and then combines this with the current OSHPD reporting.

Healthcare Outcomes Center: Joseph Parker, Ph.D.

Within the Healthcare Outcomes Center, there are two areas that produce reports on quality of care provided by hospitals. The clinical data programs include the once

voluntary heart bypass surgery program (CABG) and the mandatory CABG program. The intensive care unit outcome study is just being completed. There are four professional staff, two of which are site contractors and some students.

The administrative data program has a mandate to report on the quality of hospital outcomes for particular procedures, which are decided upon by OSHPD and its Technical Advisory Committee (TAC). Two staff positions have been vacant for over one year, which has slowed down the progress of the reports. It is difficult to recruit persons within State Government at the Ph.D. level. OSHPD has contracts with universities to develop the methodology for the quality of care reports.

The University of California at Davis provides most of the support for the CABG reports and development of the hip fractures and maternal outcomes reports. The University of California at San Francisco provides the support for the Intensive Care Unit (ICU) report, and Dr. Andy Bindman is working on a report investigating additional data elements for collection as part of the OSHPD Patient Discharge Data (see below).

The Community-Acquired Pneumonia report was released in 2004, using 2001 data, and was the first report to use do-not-resuscitate order within 24 hours after admission to a hospital and condition present at admission as risk factors. A 30-day mortality was used as a measure of quality. Staff is updating the report with 2002 to 2004 data, and waiting for death file linkage from DHS. The report will probably be released in the summer of 2006.

There have been three reports on heart attacks (AMI). Because of changes in clinical practices at hospitals and advances in care for cardiac patients, there is a need to re-estimate the risk model upon which the risk-adjusted mortality rates are calculated. A technical report on how to accomplish this is expected by the end of the month.

A validation report for maternal outcomes has been delivered to OSHPD about the feasibility of reliably measuring patient outcomes using patient discharge data linked with the Vital Statistics birth file. The two outcome measures are postpartum maternal readmission within 30 days and third and fourth degree perineal lacerations. Because of delays by the contractor, the 1999-2001 data will need to be updated, probably using 2003-2006 data. Staff is working with the contractor to develop a new timeline for completion of the report, which will probably be in late 2006.

The hip fracture study is waiting for a validation report from the same contractor as the maternal outcomes study. The validation study used much older data. There are issues regarding the need for possible model redevelopment and updating it, using some of the new fields that have been added to the discharge data. The contractor was not asked to actually write the public report, but OSHPD needs some computer programs and other information from the contractor in order to prepare the report internally. This report may be available in late 2006 or early 2007.

The last report of the former voluntary heart bypass mortality reporting program was based on 2000-2002 data. This was a joint collaborative between OSHPD and the Pacific Business Group on Health and resulted in three different reports. More than 80

out of the 120 hospitals performing CABG surgeries participated during the reporting period, although some dropped out. In the last report 77 hospitals participated.

The in-hospital mortality rate was approximately three percent. Some literature had sought to determine if there is a link between the number of surgeries performed and the outcomes of the patients. The last report found a significant, but weak, relationship between hospital volume and risk-adjusted mortality. Literature suggests there is probably a stronger link between surgeon volume and patient outcomes.

Legislation enacted in 200l required mandatory reporting of CABG procedures by all hospitals, which began January 2003. The risk-adjusted mortality has been changed from inpatient mortality to a measure called operative mortality, which includes any death that happens within the inpatient stay for the original surgery, or within 30 days of the surgery. The reports are due annually, beginning in 2005. Hospitals have a 60-day period to review the results of the report. This report has just been completed and is undergoing final review. Surgeons will begin reporting in 2006. There will be auditing of medical charts of 40 hospitals that perform CABG surgeries to verify the clinical data is the same as reported to OSHPD.

OSHPD has legislative authority to collect up to 15 additional data elements over any five-year period. National data standards will not be counted in the 15 additional data elements. Dr. Andy Bindman at UCSF has a contract to make recommendations for expanding the administrative data set. Criteria in the legislation was to minimize the administrative burden of reporting by hospitals, standardize the data elements, linkage with existing databases, and improve the methods and databases used for quality assessment. Dr. Bindman conducted a literature review of other states, conducted focus groups and interviews with data users and providers, and worked with the national standards committees. Dr. Bindman was requested to produce a report to guide OSHPD in the decision making process, and a preliminary report has been received.

The guidelines were based on the Institute of Medicine dimensions of care: safety, timeliness, efficiency, equity, effectiveness, and patient centeredness; prioritized data elements that will be useful in evaluating health care performance across a range of clinical conditions; and prioritized data elements for which there are standardized definitions at the national level. The variables with existing national standards to incorporate into OSHPD's patient level administrative datasets are: address (geocoded), including codes for housing status (e.g., homeless); vital signs (blood pressure, heart rate, respiratory rate, temperature, oxygen saturation); laboratory values (initial hematocrit, white blood cell count, platelet count, serum creatinine, blood urea nitrogen (BUN), sodium, potassium); tobacco smoking status; and time of procedures. Other potential variables of high interest include date/time of ICU admit/discharge, body mass index (BMI), and functional status.

The timing for implementation has not been specified and is complicated by future migration of the MIRCal system to an ICD-9/ICD-10 reporting format, and possible upgrades that are being considered. Some of the data elements based on national standards might require some clarification.

There is a big improvement in the ability of the risk model to distinguish mortality by supplementing clinical information with the patient discharge data. It improves the validity of the risk-adjusted outcomes.

A question was asked if there was any discussion about linking this information with other studies such as the Wennburg study on outcomes variation just completed in California. Dr. Wennburg will present this to the CHA board in April. Lawrence Baker at Stanford worked with him on this study. Dr. Parker said he would like to attend the April meeting.

Dr. Carlisle said a Health Affairs article mentioned outcome studies and thought it would be good if policymakers would pay more attention to geographic variation and outcomes, because it is fairly wide in California.

Other elements proposed are: patient's medical record number and mother's medical record number, mostly to track newborns (do not usually have a Social Security number) across admissions and discharges, the attending physician ID, patient primary language (waiting for a national standard), time of admission.

This preliminary was presented to the Commission in December, but has not been presented to the TAC. OSHPD wants to make sure that the process is very deliberate and very participatory because this is the first major augmentation of the discharge dataset in many years. This would enhance the ability to understand healthcare in the State of California.

Chairman Genna said he wanted the Committee to be sure that any element that is added is meaningful and will add to the outcome studies. This information will also aid outside organizations doing other research studies. In the literature research, there is history about the utility of each of these measures.

The Healthcare Quality and Analysis Division will be expanding the portfolio, using some different methodologies. These additional variables will allow OSHPD to fast-track additional outcome reports that are being designed now.

Dorel Harms requested when this is again discussed to identify each of the elements as collected by another organization. Vital signs and lab values will be a burden on facilities to collect and report, especially for smaller and rural hospitals.

Some things that were considered and decided that despite the interest for collecting them, would be a burden, such as functional status, activities of daily living, body mass index, height and weight, but valuable as an independent predictor of mortality and other outcomes. The day and time of ICU admission and discharge would be very valuable for studies based on ICU outcomes. There is not a national standard that defines what an ICU really is.

Dr. Carlisle said the new UCLA Medical Center has the ability to turn every medical surgery bed in the Medical Center into an ICU bed by just ordering a ventilator or IV

pressure agents to raise blood pressures. There is a two-to-one nursing ratio in that bed. The margin could become very transparent in the future.

Currently, OSHPD collects race and ethnicity as two separate data elements. The level now for compliance is high because there are tight edits on missing values for race and ethnicity.

OSHPD would probably want to consider looking at the census structure for race and ethnicity to be able to report more than one race/ethnicity for a patient.

Next Meeting Date: The next meeting will be held on Monday, May 15, 2005, in Sacramento (probably K Street office) from 9:00 a.m. – 2:00 p.m.

Adjournment: The meeting adjourned at 2:25 p.m.